

6658

CERTIFICATE OF DEATH

Reg. Dist. No. 131.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>1 Day</u>		OR (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural-R.D.#6,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Co. Chronic Hospital</u>				STREET ADDRESS (If rural give location) <u>Reich's Ford Radd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ROBERT</u> <u>LEE</u> <u>AYLOR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 2,</u> <u>19 55</u>					
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>	8. DATE OF BIRTH: <u>October 19, 1872</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Owner</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>223-36-5326</u>		17. INFORMANT & ADDRESS: <u>Lewis W. Aylor, Frederick, R.F.D.#6, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>2 hrs</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Chronic Myocarditis</u>						<u>5 yrs +</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio Sclerosis</u>						<u>5 1/2 yrs +</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 2, 1955</u> , to <u>July 2, 1955</u> , that I last saw the deceased alive on <u>July 2, 1955</u> , and that death occurred at <u>1:15AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>B. B. Harrison</u>		ADDRESS <u>Frederick, Maryland</u>		DATE SIGNED <u>7/2/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Walkers Chapel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Orange, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison & Son, Frederick, Maryland</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1965

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6659

CERTIFICATE OF DEATH

Reg. Dist. No. 144

06630

1. PLACE OF DEATH - COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Frederick			
CITY (If outside corporate limits, write RURAL and give nearest town) Lewistown				CITY (If outside corporate limits, write RURAL and give nearest town) Lewistown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS 1			
3. NAME OF DECEASED (Type or Print) JACOB		(First) HENRY		(Last) BAER		4. DATE OF DEATH (Month) (Day) (Year) July 1 1955	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Mar. 9, 1870	
9. AGE last birthday 85 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Henry Baer			
14. MOTHER'S MAIDEN NAME Annie Sophia Ramsburg				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY No. none				17. INFORMANT Ray Baer, Lewistown, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 420.0 Acute Pulmonary Edema							
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last Arteriosclerotic Heart Disease						5 yrs.	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis							
19a. DATE OF OPERATION Aug 2, 1954				19b. MAJOR FINDINGS OF OPERATION EDST			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 2, 1954 , to July 1, 1955 , that I last saw the deceased alive on June 26, 1955 , and that death occurred at 12 P.M. , from the causes and on the date stated above.							
SIGNATURE Barry J. Phinkett, Jr., M.D.				ADDRESS Walkersville, Maryland		DATE SIGNED July 2, 1955	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF July 4, 1955		NAME OF CEMETERY OR CREMATORY Utica Cemetery		LOCATION (City, town, or county) (State) Utica, Fred. Co. Md.	
DATE REC'D BY LOCAL REG. July 4, 1955		REGISTRAR'S SIGNATURE Blaugher S. Eyles		24. FUNERAL DIRECTOR M. L. Creager & Son, Thurmont, Md.		ADDRESS	

BUREAU V. S.

JUL 6 1955

RECEIVED

6626

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE New York		COUNTY Monroe	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		LENGTH OF STAY (in this place) 4 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) Rochester		69X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) JOSEPH (Middle) J. (Last) BAIERL				4. DATE OF DEATH: (Month) July (Day) 8 (Year) 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: May 8, 1884		9. AGE last birthday: 71 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Priest				10b. KIND OF BUSINESS OR INDUSTRY: Ministry		11. BIRTHPLACE (State or foreign country): New York	
13. FATHER'S NAME: Michael Baierl				14. MOTHER'S MAIDEN NAME: Anna Kohlmaier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Herbert Hartman - Rochester, New York	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 Immediate cause (a) Coronary artery sclerosis with acute myocardial infarction Antecedent causes (s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 2 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 8, 1955 , to July 8, 1955 , that I last saw the deceased alive on July 8, 1955 , and that death occurred at 9:10 A.M. , from the causes and on the date stated above. SIGNATURE (Degree or title) R. B. Martin M.D. ADDRESS 35 E Church Frederick Md DATE SIGNED 7-8-55							
23. BURIAL, CREMATION, REMOVAL, (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		July 8, 1955		Holy Sepulchre Cemetery		Rochester, New York	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
8 July 1955		Elizabeth S. Heck		C. E. Cline & Son - 8 East Patrick Street		Frederick, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 11 1955

RECEIVED

6627

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

COUNTY **Frederick**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) **Frederick**LENGTH OF STAY
(In this place)
18 hrs.HOSPITAL OR
INSTITUTION OR
STREET ADDRESS **Memorial Hospital**

2. USUAL RESIDENCE (HOME) OF DECEASED:

Maryland

Frederick

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)
OR **Brunswick**STREET
ADDRESS **919 East "B"**

(If rural give location)

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Female5. SEX:
6. COLOR OR
RACE:
White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):
Married8. DATE OF BIRTH:
7-8-18904. DATE
OF
DEATH:

(Month)

(Day)

(Year)

July 9**1955**9. AGE, last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
yrs. Months Days Hours Min.
6510a. USUAL OCCUPATION. Give kind of
work done during most of working life,
even if **House Wife**10b. KIND OF BUSINESS OR
INDUSTRY:
Home11. BIRTHPLACE (State or foreign country):
Indiana12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME:

Crist Kimmel

14. MOTHER'S MAIDEN NAME:

Henretta Kline15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)
No16. SOCIAL SECURITY No.:
-

17. INFORMANT & ADDRESS:

E.L. Baker, Brunswick, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause

(a) **Myocardial Infarction (Atherosclerotic) Rupture**

DUE TO

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.(b) **Arteriosclerotic Heart Disease**

DUE TO

(c) **Arteriosclerosis**Interval Between
Onset And Death**1 day****6 mo.**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED

While at

Not While

Work ☐At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 8, 1955**, to **July 9, 1955**, that I last saw the deceased
alive on **July 9, 1955**, and that death occurred at **4:15 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree of title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)**Burial**

DATE THEREOF

7-12-55

NAME OF CEMETERY OR CREMATORY

Park Heights

LOCATION (City, town, or county)

Brunswick, Maryland

(State)

DATE REC'D BY LOCAL
REGISTRAR**July 9 55**

REGISTRAR'S SIGNATURE

Elizabeth G. Hark

24. FUNERAL DIRECTOR

ADDRESS

C.H. Feete and Bro. Brunswick, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 13 1955

RECEIVED

200 11 17 1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

06633

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 141

1. PLACE OF DEATH COUNTY Frederick		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Rural, Brunswick		CITY (If outside corporate limits, write RURAL and give nearest town) Rural, Brunswick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Along C and O Canal		STREET ADDRESS (If rural, give location) Along C and O Canal	
3. NAME OF DECEASED (Type or Print)	(First) Carlton	(Middle) Leimond	(Last) Banks
4. DATE OF DEATH	(Month) July	(Day) 7	(Year) 1955
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 4/6/1903
9. AGE last birthday 52 yrs.		10. If under 1 year: Months 5 Days 2 If under 24 hrs: Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Ernest Linwood Banks		14. MOTHER'S MAIDEN NAME Sadie Avy Cannon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT AND ADDRESS Mrs. Sadie Banks Gilbert, Brunswick			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
322.1 Immediate cause (a) acute alcoholism			2 days
Antecedent cause(s) (b) chronic			20 years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) Home (CITY OR TOWN) Brunswick, Md. (COUNTY) Ind. Md. (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE R. W. Barr		ADDRESS Farmington, Md. DATE SIGNED July 8 55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 7-11-55 NAME OF CEMETERY OR CREMATORY Park Heights LOCATION (City, town, or county) Brunswick, Maryland (State)	
DATE REC'D BY LOCAL REG. July 9-55		REGISTRAR'S SIGNATURE Pathryn N. Brown 24. FUNERAL DIRECTOR C.H. Feete and Bro, Brunswick, Md. ADDRESS	

BUREAU V. S.

JUL 13 1955

RECEIVED

6628

MARYLAND STATE DEPARTMENT OF HEALTH

06634

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Fred.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 CARVER Apts</u>		STREET ADDRESS (If rural, give location) <u>90 CARVER Apts</u>	
3. NAME OF DECEASED (Type or Print) <u>Chas. T. Barton</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 7 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pleasant View - Fred. Co. Md.</u>		12. CITIZENSHIP <u>Wheat</u>	
13. FATHER'S NAME <u>Edward Barton</u>		14. MOTHER'S MAIDEN NAME <u>Florence Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-9981</u>	
17. INFORMANT AND ADDRESS <u>Mary E. Barton 90 Carver Apts.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH
Thirtieth

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>home</u>		(CITY OR TOWN) <u>Frederick, Md.</u> (COUNTY) <u>Frederick, Md.</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>7-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		LOCATION (City, town, or county) <u>Petersville - Fred. Co. Md.</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>19 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Herb.</u>		24. FUNERAL DIRECTOR <u>Charles E. Hicks</u>		ADDRESS <u>Fred. Co. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUL 20 1955

RECEIVED

6661

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06635

Item 21 Film G185 8-19-55 ams

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

Frederick
 County Frederick
 City or town Camp Detrick, Frederick, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 weeks
 Hospital, institution, or street address where death occurred:
Bldg. T-112, Camp Detrick, Frederick, Md.
 How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
California State Los Angeles County
Long Beach City or town 43 X 3
 (If outside city or town limits, write RURAL and give nearest town)
2469 Pine Avenue Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war service man—active duty

3. (a) FULL NAME

BAXTER, Sgt. Charles W. RA 39151634

3. (b) Social Security Number

Unk

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced

6. (b) Name of husband or wife unknown6. (c) If alive, give age 9 April 1909 years7. Birth date of deceased (mo., day, yr.) 9 April 1909

8. AGE: Years 46 Months 3 Days 12 If less than one day
 hrs. min.

9. Birthplace Orange, Texas
 (Town, county, and state)

10. Usual occupation soldier

11. Industry or business

12. Name deceased Charles W. Baxter

13. Birthplace

14. Maiden name deceased Alva Perez

15. Birthplace

16. Informant Same as item #1

Address

17. Removal 23 July 1955
 (Burial, cremation, or removal. burial) Date thereof (month) (day) (year)

Cemetery or crematory Evergreen CemeteryLocation Orange, Texas18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland22 July 1955, HOSPITAL Elizabethtown

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

21 July 1955 0900

2D. DATE OF DEATH 21 July 1955 0900

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
15 June 1955 to 21 July 1955

and that I last saw him alive on 15 July 1955

Immediate cause of death

Acute cerebral edema

DURATION

Due to Toxicology studies in progress

Chronic & acute alcoholism

Due to

Other conditions Acute alcoholism

322.1 (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Cerebral edema acute—not complete

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Bryan

ROBERT E. BRYAN, Capt. MA MC

Address Post Surgeon Cp Detrick, Md. 22 Jul 55

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WESTERN STATE TREATMENT OF HEALTH

CERTIFICATE OF DEATH

WESTERN STATE TREATMENT OF HEALTH

DEPARTMENT OF HEALTH

STATE OF CALIFORNIA

COUNTY OF _____

CITY OF _____

DECEASED _____

DATE OF DEATH _____

PLACE OF DEATH _____

CAUSE OF DEATH _____

DATE OF DEATH _____

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BUREAU V. 3.

JUL 25 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131

Item 9, Film G184 7-29-55 et

1. PLACE OF DEATH COUNTY <u>Frederick County</u> <u>Chronic Clinic</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> TOWN <u>Frederick</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Co. Chronic Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> STREET ADDRESS <u>31 S. Bentz St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Florence</u>	(First) <u>Ellis</u>	(Last) <u>Blaiz</u>	4. DATE OF DEATH (Month) <u>7</u> (Day) <u>22</u> (Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>June 22, 1923</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Hotel</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>31 1/2</u> yrs.
13. FATHER'S NAME <u>John Pendleton</u>		14. MOTHER'S MAIDEN NAME <u>Laura Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT <u>Laura Pendleton</u>		12. CITIZEN OF WHAT COUNTRY?	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>5 year</u> <u>1 year</u>
Immediate cause <u>170X</u>	(a) <u>Carcinoma breast</u>	
Antecedent cause(s) <u>Generalized carcinoma</u>	(b) <u>Lungs and abdominal peritoneum</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>7-25-55</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1954, to July 22, 1955, that I last saw the deceased alive on July 21, 1955, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE <u>Bernard Thomas, M.D.</u>	(Degree or title)	ADDRESS <u>Frederick, Md.</u>	DATE SIGNED <u>July 23, 1955</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE <u>7-25-55</u>	NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>	LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>
DATE REC'D BY LOCAL REG. <u>23 July 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	24. FUNERAL DIRECTOR <u>Charles E. Hicks</u>	ADDRESS <u>Frederick - Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 26 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6629 CERTIFICATE OF DEATH

06637

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Virginia	COUNTY Loudoun
CITY (If outside corporate limits, write RURAL OR and give nearest town) 11 TOWN Frederick	LENGTH OF STAY (in this place) Days	OR (If outside corporate limits, write RURAL and give nearest town) TOWN Lovettsville 83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural give location) ADDRESS	
3. NAME OF DECEASED: (First) (Middle) (Last) BABY DIANE BRAMHALL		4. DATE (Month) (Day) (Year) OF DEATH: July 22, 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 22 July 1955
9. AGE last birthday yrs.		10. BIRTHPLACE (State or foreign country): Maryland	
11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Millard Bramhall		14. MOTHER'S MAIDEN NAME: Mae Hawkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Millard Bramhall, Lovettsville, Va.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Fetal Disturbance Fetus</u>		From birth	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 22 July, 1955, to 22 July, 1955, that I last saw the deceased alive on 22 July, 1955, and that death occurred at 6:20A M, from the causes and on the date stated above. SIGNATURE <u>A. M. P. [Signature]</u> M.D. Frederick, Maryland DATE SIGNED 22 July 1955			
23. BURIAL CREMATION: REMOVAL (SPECIFY) Burial		DATE THEREOF 22 July 1955	
NAME OF CEMETERY OR CREMATORY Union Cemetery		LOCATION (City, town, or county) (State) Lovettsville, Virginia	
DATE REC'D BY LOCAL REGISTRAR 22 July 1955		REGISTRAR'S SIGNATURE <u>Elizabeth G. Hack</u>	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-10-53

2075-242386

BUREAU V. S.

JUL 25 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6663
CERTIFICATE OF DEATH

Reg. Dist. No. 139

06638

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Anne Arundel County
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cullen	LENGTH OF STAY (in this place) 150 days.	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Edgewater P.O., Woodland Beach	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital		STREET ADDRESS (If rural give location) 02X-2	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) Edward	(First) Emmott	(Middle) Burton	(Last) OF DEATH: July 14, 1955
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower	8. DATE OF BIRTH: Sept. 16, 1873
9. AGE last birthday: 81 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer		10B. KIND OF BUSINESS OR INDUSTRY: Printer	
11. BIRTHPLACE (State or foreign country): District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: William E. Burton		14. MOTHER'S MAIDEN NAME: Amelia Handy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT & ADDRESS: Patient			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis			9 months.
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 14, 1955, to July 14, 1955 that I last saw the deceased alive on July 14, 1955, and that death occurred at 5:30 AM, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
J. B. Lyon		July 14, 1955	
M. D. Cullen, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-16-55	
NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		LOCATION (City, town, or county) (State) Pri. Geo. Co., Md.	
DATE REC'D BY LOCAL REGISTRAR 7/14/55		24. FUNERAL DIRECTOR ADDRESS W.W. Chambers, Riverdale, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 11

MAY 18 1955

RECEIVED

VS. A15

U.S. DEPARTMENT OF JUSTICE

6630

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write OR and give nearest town)		RURAL and give nearest town)	
<i>Frederick</i>		<i>60 yrs.</i>		<i>Frederick</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>Frederick Mem. Hospital</i>				<i>303 Rockwell Terrace</i>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <i>Mrs. Bessie M.</i>		(Middle) <i>Clapp</i>		(Month) <i>July</i>		(Day) <i>2</i>	
(Type or Print)				(Year) <i>1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		
<i>F</i>	<i>W</i>	<i>married</i>	<i>7-20-1882</i>	<i>72</i> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>Housewife</i>				<i>Own Home</i>		<i>Maryland</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Douglas H. Hargett</i>				<i>Emma M. Whipp</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<i>No</i>				<i>none</i>		<i>Frederick - Md.</i>	
				<i>M. Robt. E. Clapp - 303 Rockwell Terrace -</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
151X Immediate cause (a) <i>Carcinoma of the Stomach with Metastases to Liver and Spleen</i>						<i>9 mo.</i>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.						<i>Bronch. Pneumonia</i>	
19a. DATE OF OPERATION:						20. AUTOPSY?	
<i>Oct. 30, 1954</i>						<i>2 days</i>	
19b. MAJOR FINDINGS OF OPERATION						<i>Carcinoma of Stomach with Spleen Metastases</i>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		OF INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from <i>April 6, 1955</i> , to <i>July 2, 1955</i> , that I last saw the deceased alive on <i>July 2, 1955</i> , and that death occurred at <i>4:10 P.M.</i> from the causes and on the date stated above.							
SIGNATURE (Degree or title)				DATE SIGNED			
<i>H. A. Gearre M.D.</i>				<i>Frederick Md. 7/2/55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>7-6-1955</i>		<i>Mt. Olivet Cemetery</i>		<i>Frederick - Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>5 July 1955</i>		<i>Elizabeth B. Heik</i>		<i>C. E. Chine & Son - Frederick - Md.</i>			

BUREAU V. 21

JUL 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6631 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06640
 Item 2 by Phone to Baptist Home, 8/1/55 ams
CERTIFICATE OF DEATH Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>3 Weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore/ Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Three Pines Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Baptist Home of Maryland</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JEAN MASON COLLUMS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 28, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>April 15, 1870</u>	
9. AGE last birthday: <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William E. Mason</u>				14. MOTHER'S MAIDEN NAME: <u>Cornelia (last name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>College Place, Mr. A.B. Collmus, Frederick, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Bronchitis - Pneumonia</u>						3 days	
(B) <u>Arteriosclerotic Heart Disease</u>						1 yr	
(C) <u>Arteriosclerosis (Generalized)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Paget's Disease</u>						Several years	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 19, 1955</u> , to <u>July 28, 1955</u> , that I last saw the deceased alive on <u>July 27, 1955</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>A. A. Pearse</u>				ADDRESS <u>Frederick, Maryland</u>		DATE SIGNED <u>7/29/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 30, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmont Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>29 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		24. FUNERAL DIRECTOR ADDRESS <u>Mr. R. Etchison & Son, Frederick, Maryland</u>			

BUREAU V. S.

AUG 1 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

06641

6664

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 134

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Emmitsburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Emmitsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>R.D.1</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>RUTHELLA LYNN COOL</u>		<u>JULY 7, 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>3-17-1955</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday yrs. <u>3</u> Months <u>20</u> Days <u>0</u> Hours <u>0</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Daniel S. Cool</u>		14. MOTHER'S MAIDEN NAME <u>Geraldine Trent</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Emmitsburg, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
491X Immediate cause (a) <u>Bronchopneumonia</u>			<u>Days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>NONE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>R.W. Baer</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-9-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		LOCATION (City, town, or county) (State) <u>Emmitsburg, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>July 8-1955 M.F. Shuff</u>		24. FUNERAL DIRECTOR <u>S.L. Allison</u> Emmitsburg, Maryland	

2035318384

RECEIVED

JUL 12 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6665 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18 Film G184 8-9-55 ams

06642

CERTIFICATE OF DEATH

Reg. Dist. No. 147

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Mt. Airy</u>		<u>11 years</u>		OR TOWN <u>Rural - Mt. Airy</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
-				<u>Beyond end of Plainview Ave - Mt. Airy</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
(Type or Print) <u>Howard</u> (None) <u>Davis</u>		DATE OF DEATH: <u>July</u> <u>30</u> <u>1955</u>					
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>October 19, 1938</u>	9. AGE last birthday: <u>16</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Harry E. Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Lorraine Butler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No.</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Mary Insley (Great Aunt) Mt. Airy</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Rheumatic Heart Disease</u>						<u>7 years</u>	
DUE TO							
ANTECEDENT CAUSE (B) <u>Rheumatic Fever (not active)</u>						<u>9 years</u>	
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 1955, to <u>July</u> , 1955, that I last saw the deceased alive on <u>July 11</u> , 1955, and that death occurred at <u>10:15</u> A M, from the causes and on the date stated above.							
SIGNATURE <u>W.B. Culwell</u>		M.D. <u>Mt. Airy, Md</u>		DATE SIGNED <u>July 30, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-2-1955</u>		<u>Mt. Zion</u>		<u>Carroll Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Aug. 2, 1955</u>		<u>Blaise A. Runkles</u>		<u>Ed M. Waltz</u>		<u>Winfield, Md.</u>	

RECEIVED

AUG 4 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06643

6632

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL or and give nearest town) Frederick		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) OR Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 634 Grant Place			
3. NAME OF DECEASED: (First) (Middle) (Last) ANNETTE JESTINE DETERDING				4. DATE (Month) (Day) (Year) OF DEATH JULY 28 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow	8. DATE OF BIRTH: December 29, 1877	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY: Home		11. BIRTHPLACE (State or foreign country): Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Samuel Hunter				14. MOTHER'S MAIDEN NAME: Ann Robinson Bell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year no, or unk.) (If Yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: 202 West 12th Street, Samuel F. Deterding, Frederick, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 420.0						24 hours	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Gangrene Small Bowel							
(B) Arterio-sclerotic and hypertensive							
(C) heart disease						30+ years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pericarditis						5-6 wks.	
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1946 , to 28 July , 19 55 , that I last saw the deceased alive on 28 July , 19 55 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
SIGNATURE Charles H. Conley, Jr.		M.D. Frederick, Maryland		DATE SIGNED 7/28/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 31, 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 29 July 1955		REGISTRAR'S SIGNATURE Elizabeth B. Hesch		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

RECEIVED

AUG 1 1955

BUREAU V. S.

6633

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL or and give nearest town) 11 Town Frederick		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) OR Town Frederick 11			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 522 Klineharts Alley			
3. NAME OF DECEASED: (First) (Middle) (Last) ERNEST WEEDON DIXON				4. DATE (Month) (Day) (Year) OF DEATH: July 6, 19 55			
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: March 22, 1897	9. AGE last birthday 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 64 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Unknown		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William Dixon				14. MOTHER'S MAIDEN NAME: Dora Harmon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 217-10-9268		17. INFORMANT & ADDRESS: 522 Klineharts Alley, Mrs. Bertie Goines, Frederick, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 442x							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) DUE TO Hypertensive cardiovascular and disease						6 mos.	
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 2, 1955 , to July 6, 1955 that I last saw the deceased alive on July 6, 1955 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. SIGNATURE Dr. B. Martin ADDRESS Frederick, Maryland DATE SIGNED 7/8/1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 9, 1955		NAME OF CEMETERY OR CREMATORY Fairview Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 8 July 1955		REGISTRAR'S SIGNATURE Elizabeth B. Hake		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. 3.

JUL 11 1955

RECEIVED

6634

MARYLAND STATE DEPARTMENT OF HEALTH

06645

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH - COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>173 West Patrick Street</u>		STREET ADDRESS (If rural, give location) <u>173 West Patrick Street</u>	
3. NAME OF DECEASED (First) <u>EVA</u> (Middle) <u>MAY</u> (Last) <u>DIXON</u>	4. DATE OF DEATH (Month) <u>July</u> (Day) <u>15</u> (Year) <u>1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10 June 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	9. AGE last birthday <u>44</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Shipe</u>		14. MOTHER'S MAIDEN NAME <u>Flora Cole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Russell L. Shipe, Brunswick, Maryland</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<u>981X</u> Immediate cause (a) <u>Gun Shot Wound Left Chest</u>		<u>5 Minutes ?</u>
Antecedent cause(s) (b) <u>(38 Cal. Revolver)</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION <u>7/15/55</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u> INJURY <u>Home</u>	(CITY OR TOWN) <u>Frederick</u> (COUNTY) <u>Frederick</u> (STATE) <u>Maryland</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/15/55 8:30 PM</u> INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Homicide</u>	

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☒ undetermined ☐.

SIGNATURE D.W. Ban

(Degree or title)

ADDRESS

DATE SIGNED

M. D. Deputy Medical Examiner, Frederick, Maryland

19 July 1955

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>20 July 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	LOCATION (City, town, or county) <u>Knoxville, Maryland</u> (State)
---	----------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>19 July 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth L. Heck</u>	24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>	ADDRESS
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 20 1955

RECEIVED

6635

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

COUNTY Frederick MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick LENGTH OF STAY (in this place) 1 mo.HOSPITAL OR INSTITUTION OR STREET ADDRESS Three Pines Nursing Home Military Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY Frederick
~~OR~~ outside corporate limits, write RURAL and give nearest town) Walkersville XSTREET ADDRESS (If rural give location) Walkersville /

3. NAME OF DECEASED:

(First) (Middle) (Last)
(Type or Print) EFFIE CONOVER ELDER

5. SEX:

F

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

widowed July 16, 1865

8. DATE OF BIRTH:

9. AGE last birthday 89 yrs.

10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

-

11. BIRTHPLACE (State or foreign country):

New Jersey

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Nathan S. Conover

14. MOTHER'S MAIDEN NAME:

Matilda Hunt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Mrs. Frank C. Nicodemus, Walkersville, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE

(A)

DUE TO Hypertensive Arteriosclerotic Heart Disease

ANTECEDENT CAUSE (S)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

1) generalized arteriosclerosis
2) fracture of hip (pneumia)

INTERVAL BETWEEN ONSET AND DEATH

5 yrs

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 14, 1954 to July 4, 1955, that I last saw the deceasedalive on June 27, 1955, and that death occurred at 6:25 PM, from the causes and on the date stated above.

SIGNATURE

B. J. Plunkett, Jr. M.D.

ADDRESS

Walkersville, Md.

DATE SIGNED

July 5, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

7/7/1955

NAME OF CEMETERY OR CREMATORY

Boxton Church yard

LOCATION (City, town, or county)

Harrisburg,

(State)

Pa.

DATE REC'D BY LOCAL REGISTRAR

6 July 1955

REGISTRAR'S SIGNATURE

Elizabeth B. Heck

24. FUNERAL DIRECTOR

F.C. Boxton, Walkersville, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 7 1955

RECEIVED

6668

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Near Frederick</u>	LENGTH OF STAY (in this place) <u>25 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Route 5 - Nr. Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Emergency Hospital</u>		STREET ADDRESS (If rural give location) <u>Gambrill Park Road</u>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>NELLIE</u>	(Middle) <u>M.</u>	(Last) <u>ESTABROOK</u>	(Date) <u>July 14 19 55</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>1858</u>
9. AGE last birthday: <u>97</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country): <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George Melling</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Nellie M. Winchester - Frederick, Md.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.0 Immediate cause		
(a) <u>Arterio-sclerotic heart dis. w/</u>		
DUE TO <u>auricular Fibrillation and</u>		
(b) <u>congestive failure</u>		
DUE TO		
(c)		
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. <u>malignancy left breast</u>		
19a. DATE OF OPERATION: <u>0</u>		20. AUTOPSY? <u>?</u>
19b. MAJOR FINDINGS OF OPERATION		

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from <u>30 Apr.</u> , 19 <u>53</u> , to <u>11 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8 July</u> , 19 <u>55</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE		ADDRESS		DATE SIGNED	
<u>Charles H. Conley</u>		<u>Frederick, Md.</u>		<u>15 July 1955</u>	
23. BURIAL CREMATION, (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>		<u>July 16, 1955</u>	<u>Mount Olivet Cemetery</u>	<u>Frederick,</u>	<u>Maryland</u>
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<u>15 July 1955</u>		<u>Elizabeth B. Heck</u>	<u>C. E. Cline & Son - 8 East Patrick Street - Frederick, Maryland</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

18 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

07732

2411 N. Charles Street, Baltimore

6636

CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH: COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY FREDERICK	
CITY (If outside corporate limits, write RURAL and give nearest town) 11 TOWN FREDERICK		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN NEW MARKET	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 FREDERICK MEMORIAL HOSPITAL		STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED (First) (Middle) (Last) ELIZABETH CARSON FALCONER		4. DATE OF DEATH (Month) (Day) (Year) JULY 11 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH FEB 22 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE last birthday 41 yrs.
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL COUGHLIN		14. MOTHER'S MAIDEN NAME MARY NEW TON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY No. —	
17. INFORMANT AND ADDRESS W.E. FALCONER NEW MARKET MD			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 days
5 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **July 7, 1955** to **July 11, 1955**, that I last saw the deceased alive on **July 11, 1955**, and that death occurred at **1305** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF JULY 14 1955	NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETARY	LOCATION (City, town, or county) FREDERICK	(State) MD
DATE REC'D BY LOCAL REG. July 13 1955	REGISTRAR'S SIGNATURE Lucian K Falconer	24. FUNERAL DIRECTOR W.E. Falconer	ADDRESS NEW MARKET MD	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 19 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Brunswick		70 years		TOWN Brunswick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 309 East Potomac				STREET ADDRESS 309 East Potomac			
3. NAME OF DECEASED:		(First) Annie		(Middle) Margaret		(Last) Flynn	
(Type or Print)							
4. DATE OF DEATH:		(Month) 7		(Day) 2		(Year) 19 55	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Female		White		Widowed		2-19-1872	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
83		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
House wife				Home		West Virginia	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Lloyd Harper				Virginia Forney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
No				-		E.H.Flynn, Brunswick, Maryland	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
450.0 Immediate cause (a) Chronic leukemia						7	
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
Fracture							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF		While at					
INJURY		M. work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 4/26/54 to 7/2/55 , that I last saw the deceased alive on 7/2/55 , and that death occurred at 6:00 p.m. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS [Address]			
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-5-1955		Park Heights		Brunswick, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
July 4-55		Kathryn N. Brown		C.H. Peete and Bro.		Brunswick, Md.	

BUREAU V. S.

JUL 7 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6667
CERTIFICATE OF DEATH

06649

Reg. Dist. No. 134

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Md.	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Emmitsburg, Md. Rural	LENGTH OF STAY (in this place) 12 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Emmitsburg, Md. Rural X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural give location) 1	
3. NAME OF DECEASED: (First) Viola (Middle) May (Last) Fury		4. DATE (Month) (Day) (Year) OF DEATH: 7 31 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 5/25/76
9. AGE last birthday 79 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Beautician	
11. BIRTHPLACE (State or foreign country): Frederick County Md.		12. CITIZEN OF WHAT COUNTRY? Citizen USA	
13. FATHER'S NAME: David Reightler		14. MOTHER'S MAIDEN NAME: Tobiatha Fleagle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-6386	
17. INFORMANT & ADDRESS: Robert H. Fury Emmitsburg, Md. RFD			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) myocardial failure			8 hrs.
ANTECEDENT CAUSE (B) chronic myocarditis			?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arteriosclerosis			?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Bronchial asthma			?
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar. 2, 1948 to July 31, 1955 that I last saw the deceased alive on July 31, 1955 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
SIGNATURE M. J. [Signature]		DATE SIGNED Aug. 1, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/3/55	
NAME OF CEMETERY OR CREMATORY U.B. Cemetery		LOCATION (City, town, or county) (State) Thurmont, Md. Frederick Co.	
DATE REC'D BY LOCAL REGISTRAR 8-3-55 M.L. Creager		24. FUNERAL DIRECTOR ADDRESS M.L. Creager and Son Thurmont, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 8 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06650

6668

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland COUNTY Balto. City			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cullen		LENGTH OF STAY (in this place) 708 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital		STREET ADDRESS (If rural give location) 1329 Linden Avenue					
3. NAME OF DECEASED: (First) (Middle) (Last) Richard L. Goodrich				4. DATE (Month) (Day) (Year) OF DEATH: July 2 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Dec. 8, 1908	9. AGE last birthday 46 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter HousePainter			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Bath, New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Lionel Goodrich				14. MOTHER'S MAIDEN NAME: Harriet Story			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes W. W. I.				16. SOCIAL SECURITY NO. 073-16-6037		17. INFORMANT & ADDRESS: Mrs. Mae J. Goodrich, Wife, Same address.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis						2½ years.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 24, 1953 , to July 2 , 19 55 that I last saw the deceased alive on July 2, 1955 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
SIGNATURE [Signature]		M. D. Cullen, Maryland		DATE SIGNED July 5, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Delivered		DATE THEREOF 7-14-55		NAME OF CEMETERY OR CREMATORY Dept. of Anatomy, U. of M.		LOCATION (City, town, or county) (State) Balto, Md.	
DATE REC'D BY LOCAL REGISTRAR 7/5/55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR		ADDRESS	

BUREAU V. S.

JUL 6 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6657 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06651

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH: Frederick				2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland Frederick			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 35 Brunswick		LENGTH OF STAY (in this place) 50 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 515 Brunswick Street				STREET ADDRESS (If rural, give location) 515 Brunswick Street			
3. NAME OF DECEASED: (Type or Print) Earl (First) Carlton (Middle) Grams (Last)				4. DATE OF DEATH: 7 - 4 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married	8. DATE OF BIRTH: 8-31-1886-1885	9. AGE last birthday: 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired, so state) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY: Band O.R.R.Co.		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Thomas E. Grams				14. MOTHER'S MAIDEN NAME: Addie Haines			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Florence May Grams, Brunswick, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>420.1 Immediate cause (a)..... Coronary Thrombosis DUE TO</p> <p>Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO</p> <p>(c).....</p>							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:						19b. MAJOR FINDINGS OF OPERATION:	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/18/55 to 7/14/55 , that I last saw the deceased alive on 7/14/55 , and that death occurred at 7:30 p.m., from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS [Address]			
23. BURIAL, CREMATION (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-7-1955		Locust Valley		Rural Burkittsville, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
July 6-55		Kathryn H. Brown		C.H. Feete and Bro. Brunswick, Md.			

BUREAU V. 2

JUL 11 1955

RECEIVED

6637

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 11 TOWN Frederick		LENGTH OF STAY (in this place) 2 Weeks		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Thurmont-Rural RD#1 X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital				STREET ADDRESS (If rural give location) Lewistown /			
3. NAME OF DECEASED: (First) LAVINA		(Middle) KATHERINE		(Last) GREEN		4. DATE OF DEATH: (Month) July 17, (Day) 19 (Year) 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 7 Sept 1900	9. AGE last birthday: 54 yrs.		If UNDER 1 YEAR If UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House-work		10b. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Edward Powell				14. MOTHER'S MAIDEN NAME: Susan Holdcraft			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: George W. Green, RD#1, Thurmont, Maryland			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
154X Immediate cause (a) Intestinal Obstruction						13 days	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma of Recto. sigmoid						3 1/2 yrs.	
(c) Exploratory Operation - Reaction to in. ileum						4 days.	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: July 5-1955				19b. MAJOR FINDINGS OF OPERATION Abdomino-perineal resection Exploratory - Recurrence of carcinoma & obstruction of ileum			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
				Thurmont R.D. #1		Frederick Md	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
g		m.					
22. I hereby certify that I attended the deceased from July 4, 1955, to July 17, 1955, that I last saw the deceased alive on July 17, 1955, and that death occurred at 3:55 P.M., from the causes and on the date stated above.							
SIGNATURE Frank W. Horthington				ADDRESS M. R. Etchison - Ind.		DATE SIGNED July 17-1955	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		20 July 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
19 July 1955		Elizabeth B. Heeb		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 20 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06653

6669

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:							
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick						
CITY (If outside corporate limits, write RURAL and give nearest town) Lander		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick							
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenmerrie Nursing Home		STREET ADDRESS (If rural give location) 501 Lee Place							
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:							
(Type or Print) NELLIE BETORIS GREEN		July 2, 1955							
5. SEX:	6. COLOR OR RACE:	7. SINGLE , MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:						
Female	White	Widow	11 June 1880						
9. AGE last birthday	10. DATE OF BIRTH:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?						
75 yrs.	11 June 1880	Maryland	USA						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:							
House-work		Own Home							
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:							
Andrew Haines		Mary Miller							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.							
No		None							
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION							
501 Lee Place, Mrs. Cecil D. Clay, Frederick, Maryland		<table border="1"> <tr> <td>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</td> <td>INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td> 331X IMMEDIATE CAUSE (A) Malnutrition - Numerous ANTECEDENT CAUSE (S) infected Pressure ulcers DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Cerebral Hemorrhage </td> <td> 4 mo 2 yrs 1 mo </td> </tr> <tr> <td>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Phlebitis Left thigh</td> <td></td> </tr> </table>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH	331X IMMEDIATE CAUSE (A) Malnutrition - Numerous ANTECEDENT CAUSE (S) infected Pressure ulcers DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Cerebral Hemorrhage	4 mo 2 yrs 1 mo	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Phlebitis Left thigh	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH								
331X IMMEDIATE CAUSE (A) Malnutrition - Numerous ANTECEDENT CAUSE (S) infected Pressure ulcers DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Cerebral Hemorrhage	4 mo 2 yrs 1 mo								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Phlebitis Left thigh									
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from Dec , 1954 to 7/2 , 1955 that I last saw the deceased alive on 6/30 , 1955 and that death occurred at 6:40A M, from the causes and on the date stated above. SIGNATURE C. D. Brice M. D. Jefferson Maryland 2 July 1955 DATE SIGNED									
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)						
Burial	5 July 1955	Utica Lutheran Cemetery	Frederick County Maryland						
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS							
3 July 1955	Elizabeth S. Heck	M. R. Etchison & Son, Frederick, Maryland							

BUREAU V. S.

JUL 7 1955

RECEIVED

6670

CERTIFICATE OF DEATH

Reg. Dist. No. 140...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Le Gore</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Le Gore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		STREET ADDRESS (If rural give location) <u>/</u>	

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
BLANCHE CORILLA GRIMES		DEATH: <u>July</u> <u>22</u> <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed Mar. 12, 1892</u>	8. DATE OF BIRTH: <u>63</u> yrs.
9. AGE last birthday <u>63</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>General</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Rubber Co. & Canning</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jacob Potts</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Loudan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-14-6849</u>	
17. INFORMANT & ADDRESS: <u>Mr. Sheridan L. Grimes, Le Gore, md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		
ANTECEDENT CAUSE (S) DUE TO (B) <u>Diabetes</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(260X)</u>		(C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>7/24/55</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from <u>July 15, 1955</u> to <u>July 22, 1955</u> that I last saw the deceased alive on <u>July 15, 1955</u> and that death occurred at <u>Le Gore, Md.</u> from the causes and on the date stated above.	
SIGNATURE <u>J. D. Missin</u>	DATE SIGNED <u>July 24, 1955</u>

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7/24/55</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>	LOCATION (City, town, or county) <u>Le Gore</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>7/24/55</u>	REGISTRAR'S SIGNATURE <u>L. C. Powell</u>	24. FUNERAL DIRECTOR <u>Y. C. Bastin, Walkersville, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUL 27 1955

RECEIVED

06655

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6671

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Creagerstown rural	LENGTH OF STAY (in this place) 12 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Creagerstown Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural give location) 1	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Ralph	(Middle) Harrison	(Last) Grinder	OF July 23 19 55
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH: February 27 1888
9. AGE last birthday: 67 yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Adjudicator		10B. KIND OF BUSINESS OR INDUSTRY: Veterans Amd.	11. BIRTHPLACE (State or foreign country): Creagerstown Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: John Wesley Grinder	
14. MOTHER'S MAIDEN NAME: Eleanor Baker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unk.) (If Yes, give branch and dates of service) Yes id War I	
16. SOCIAL SECURITY NO.: no		17. INFORMANT & ADDRESS: Mrs. Esther Grinder Creagerstown	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 163X Carcinomatosis			4 mos.
ANTECEDENT CAUSE (S) DUE TO (B) Carcinoma of right lung			8 mos.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic myocarditis			5 yrs.
19A. DATE OF OPERATION: Jan. 31, 1955		19B. MAJOR FINDINGS OF OPERATION: Carcinoma of lower lobe of right lung	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 5, 1955 to July 23, 1955 , that I last saw the deceased alive on July 22, 1955 , and that death occurred at 3:45 AM , from the causes and on the date stated above.			
SIGNATURE M. Franklin Birch		DATE SIGNED July 23, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 25 1955	
NAME OF CEMETERY OR CREMATORY Creagerstown Cem.		LOCATION (City, town, or county) (State) Creagerstown Md.	
DATE REC'D BY LOCAL REGISTRAR July 25 1955		REGISTRAR'S SIGNATURE Blanche S. Eyles	
24. FUNERAL DIRECTOR M. C. Eager		ADDRESS San Thurmston Md	

BUREAU V. S.

JUL 26 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06656

6672

CERTIFICATE OF DEATH

Reg. Dist. No. 139.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland COUNTY Baltimore City			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cullen		LENGTH OF STAY (in this place) 13 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR Baltimore		31014	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital				STREET ADDRESS (If rural give location) 9 West Lee Street,		V	
3. NAME OF DECEASED: (Type or Print)		(First) Emma		(Middle) May		(Last) Harksen	
4. DATE (Month) (Day) (Year) OF DEATH:		July		21		1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Divorced	5/27/1899	56 yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Housewife		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Frederick Eckarius				14. MOTHER'S MAIDEN NAME: Anna ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT & ADDRESS: Emma May Harksen, 9 W. Lee St., Baltimore, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Metastatic carcinoma of liver.						Unknown.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Carcinoma of head of Pancreas.						Unknown.	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary Tuberculosis						4 months.	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 8 , 19 55 to July 21 , 19 55 , that I last saw the deceased alive on July 21 , 19 55 , and that death occurred at 10:25 M. from the causes and on the date stated above.							
SIGNATURE [Signature]		A.M. ADDRESS Cullen, Md.		DATE SIGNED July 21, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-25-55		NAME OF CEMETERY OR CREMATORY Loudon Park		LOCATION (City, town, or county) (State) Baltimore	
DATE REC'D BY LOCAL REGISTRAR 7/21/55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR [Signature]		ADDRESS 715 Lite St	

BUREAU V. S.

JUL 26 1955

RECEIVED

6638

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL or and give nearest town) // TOWN Frederick		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick //			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 67 Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 130 West Fourth Street			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
ROSA		CLARA		HAUSLER		4. DATE (Month) (Day) (Year) OF DEATH: July 25, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Married	September 24, 1888	66 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housework		Home		Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Anthony F. Wickless				Laura Joy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		None		Mrs. Richard E. Brown, Frederick R.F.D.#5, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						24 hours	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertensive heart disease</u>						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/24, 1955, to 7/25, 1955, that I last saw the deceased alive on 7/25, 1955, and that death occurred at 3:55 P.M. from the causes and on the date stated above.							
SIGNATURE James B. Thomson				ADDRESS M.D. Frederick, Maryland		DATE SIGNED 7/26/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 28, 1955		St. Johns Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
26 July 1955		Elizabeth G. Heck		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

RECEIVED

JUL 27 1955

BUREAU V. S.

6639

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <i>Frederick</i>		LENGTH OF STAY (in this place) <i>2 da</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Thurmont</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Frederick Mem. Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>William</i> (Middle) <i>R</i> (Last) <i>Henshaw</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>July 8 1955</i>			
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>	8. DATE OF BIRTH: <i>March 5-1869</i>	9. AGE last birthday <i>86</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>lumber</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>lumber</i>		11. BIRTHPLACE (State or foreign country): <i>Thurmont</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John J. Henshaw</i>				14. MOTHER'S MAIDEN NAME: <i>Margaret Rouzer</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <i>no</i>				16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT & ADDRESS: <i>Miss Grace Henshaw Thurmont</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Intestinal obstruction</i>						<i>2 days</i>	
ANTECEDENT CAUSE (S) (B) <i>Infection of terminal ileum</i>						<i>3 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Anteromedullary Heart Disease with pulmonary edema</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 6, 1955</i> , to <i>July 8, 1955</i> , that I last saw the deceased alive on <i>July 8, 1955</i> , and that death occurred at <i>6 A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Henry V. Chase</i>		M. D. <i>H. S. Church Jr</i>		DATE SIGNED <i>7/8/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>July 10-1955</i>		NAME OF CEMETERY OR CREMATORY <i>W. B. Clem</i>		LOCATION (City, town, or county) (State) <i>Thurmont Fred Co Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>9 July 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth B. Heck</i>		23A. FUNERAL DIRECTOR <i>M. L. Morgan</i>		ADDRESS <i>San Thurmont Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 12 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

06659

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

6640

1. PLACE OF DEATH- COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		LENGTH OF STAY (in this place) 15 Minutes		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		TOWN //	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural, give location) 6 West Second Street		/	
3. NAME OF DECEASED (Type or Print) HENRY		(Middle) WILLIAM		(Last) HERMAN		4. DATE OF DEATH (Month) (Day) (Year) July 14, 1955	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Sept. 23, 1895	
				9. AGE last birthday 59 yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sports Editor		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Herman				14. MOTHER'S MAIDEN NAME Ella May Anthony			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 527-05-4120		17. INFORMANT AND ADDRESS W. Second St., Mrs. Agnes S. Herman, Frederick, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) CORONARY OCCLUSION		1 Hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REINTERMENT (Specify) Burial		DATE THEREOF July 17, 1955	NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	LOCATION (City, town, or county) Frederick, Maryland	(State)
DATE REC'D BY LOCAL REG. 16 July 1955	REGISTRAR'S SIGNATURE Elizabeth G. Heck	24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

18 1955

RECEIVED

6673

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cullen		1 day		TOWN Frostburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital				STREET ADDRESS (If rural give location) Route #1, Box 86			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
James T. Hitchins				OF DEATH: July 15, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married.	March 12, 1885	70 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Coal Miner		Coal Miner		Maryland		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
James Hitchins				Mary A. Stevens			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		213-05-7123		James T. Hitchins, Rt. #1, Box 86, Frostburg, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE			(A) Pulmonary Tuberculosis				Unknown
ANTECEDENT CAUSE (B)			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) DUE TO				
			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County)	(State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 14, 1955, to July 15, 1955, that I last saw the deceased alive on July 15, 1955, and that death occurred at 8:00 M. from the causes and on the date stated above.							
SIGNATURE		M. D. Cullen, Maryland		DATE SIGNED		July 18, 1955.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 18, 1955		Frostburg Memorial Park,		Frostburg, Maryland.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7/18/55				M. L. Creager & Son, Thurmont,		Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 20 1955

BUREAU V. 2

6674

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Town Lander</u>		LENGTH OF STAY (in this place) <u>Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glen Merrie Nursing Home</u>				STREET ADDRESS (If rural give location) <u>207 East Second Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES PHILIP HITESHEW Sr.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 10, 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>February 14, 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Automobiles</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>P. Merhl Hiteshe</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Keller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-5757</u>		17. INFORMANT & ADDRESS: <u>255 Washington Street</u> <u>C. Philip Hiteshe, Jr., Frederick, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>with acute congestive failure</u>							
(B) _____ DUE TO _____							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pylospasm</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/5/54</u> , 19 <u>54</u> , to <u>7/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>55</u> , and that death occurred at <u>12:30M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Henry V. Chase</u>		M. D. <u>Frederick, Maryland</u>		DATE SIGNED <u>7/11/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hebl</u>		24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

JUL 12 1955

RECEIVED

6675

CERTIFICATE OF DEATH

Reg. Dist. No. 134

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Emmitsburg,	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Emmitsburg,	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 207 West Main		STREET ADDRESS (If rural give location) 207 West Main	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Joseph	(Middle) Robert	(Last) Hoke	(Month) (Day) (Year) July 5, 1955
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Sept, 7, 1886
9. AGE last birthday: 68 yrs.		10. BIRTHPLACE (State or foreign country): Emmitsburg, Md.	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Caretaker		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Michael Hoke		14. MOTHER'S MAIDEN NAME: Laura Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 219-30-9956	
17. INFORMANT & ADDRESS: Mrs. George Ginzell		Fairfield, Pa. R.D. # 1	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
177X Immediate cause (a) Carcinoma prostate		2 years	
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 26, 1955, to July 5, 1955, that I last saw the deceased alive on July 5, 1955, and that death occurred at 2:00 PM, from the causes and on the date stated above.			
SIGNATURE W. R. Cade, M.D.		DATE SIGNED 7-6-55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		NAME OF CEMETERY OR CREMATORY St. Josephs Catholic	
DATE THEREOF July 8, 1955		LOCATION (City, town, or county) Emmitsburg, Maryland	
DATE REC'D BY LOCAL REGISTRAR July 7-1955		REGISTRAR'S SIGNATURE M. F. Shuff	
24. FUNERAL DIRECTOR S. L. Allison		ADDRESS Emmitsburg, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

6641

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>246 East Third Street</u>		STREET ADDRESS (If rural, give location) <u>246 East Third Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EFFIE</u> (Middle) <u>LUCKETT</u> (Last) <u>HAUSER HORINE</u>	4. DATE OF DEATH (Month) <u>July</u> (Day) <u>31</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>29 Jan 1890</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis Mahoney</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Ausherman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-20-1233A</u>	
17. INFORMANT AND ADDRESS <u>Willard M. Horine, Frederick, Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

Indeterminate

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) "Heart disease"2 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY NoneINJURY OCCURRED While at work ☐ Not while at work ☒HOW DID INJURY OCCUR? None

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSITION (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

August 1955Ely J. H. H. H.M. R. Etchison & Son, Frederick, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 3 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6676

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06664

CERTIFICATE OF DEATH

Reg. Dist. No. 131.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Middletown</i>	<i>40 years</i>	OR TOWN <i>Middletown</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	<i>1</i>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <i>William H. Johnson</i>		OF DEATH: <i>7 18 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:
<i>male</i>	<i>colored</i>	<i>widowed</i>	<i>6-9-1885</i>
9. AGE last birthday		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<i>70 yrs.</i>		<i>70 yrs.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<i>laborer</i>		<i>self-employed</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U.S.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Henry Johnson</i>		<i>Katherine Butler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<i>no</i>		<i>216-22-9381</i>	
17. INFORMANT & ADDRESS:			
<i>Audrey Cox, Middletown, Md.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>			<i>Suddenly</i>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Arterio Sclerosis</i>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>0</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 16, 1955</i> , to <i>July 18, 1955</i> , that I last saw the deceased alive on <i>July 17, 1955</i> , and that death occurred at <i>10:30 P.</i> M. from the causes and on the date stated above.			
SIGNATURE <i>J E Harp</i>		DATE SIGNED <i>July 19 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Reformed Cemetery</i>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<i>7-20-1955</i>		<i>Middletown, Md.</i>	
REGISTRAR'S SIGNATURE <i>Elizabeth Y. Heck</i>		24. FUNERAL DIRECTOR ADDRESS	
		<i>Gladhill Co., Middletown, Md.</i>	

BUREAU V. S.

MIL 22 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6677

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland COUNTY Frederick			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Petersville		30 years		OR TOWN Petersville		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
-				-			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Mabel C. Purce Jones				7 13 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married		8. DATE OF BIRTH: I-10-1877	
						9. AGE last birthday: 78 yrs.	
						10. USUAL OCCUPATION (Give kind of work done during most of working life, even Housewife)	
						11. BIRTHPLACE (State or foreign country): Virginia	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Alfred Newton Purce				14. MOTHER'S MAIDEN NAME: Mary Bell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				17. INFORMANT & ADDRESS:			
No				Alfred Jones, Falls Church, Va.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
331X Immediate cause (a) Hypostatic pneumonia - Lementia							
Antecedent cause(s) (b) Cerebral hemorrhages							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Advanced Cerebral Arteriosclerosis							
II. OTHER SIGNIFICANT CONDITIONS:							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
21. ACCIDENT (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE HOMICIDE				INJURY			
TIME (Month) (Day) (Year) (Hour)				INJURY OCCURRED While at Not while		HOW DID INJURY OCCUR?	
OF INJURY				M. work at work			
22. I hereby certify that I attended the deceased from....., 1950, to..... 7/13 1955, that I last saw the deceased alive on..... 7/13, 1955, and that death occurred at..... 4:30 p.m., from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE)		DATE SIGNED	
C. J. Pabst of Erie Md				Jefferson W. J.		7/14/55	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-15-55		Park Heights		Brunswick, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
July 15-55		Kathryn H. Brown		C.H. Feete and Bro. Brunswick, Md			

BUREAU V. R.

JUL 19 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06666

6678

CERTIFICATE OF DEATH

Reg. Dist. No. 140...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Rural, Walkersville</u>		<u>2 yrs.</u>		<u>Ladysburg</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>ETTA</u>		<u>MAE</u>		<u>KLINE</u>			
4. DATE (Month) (Day) (Year)		OF DEATH:		<u>July 16</u>		<u>1955</u>	
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Sept. 19, 1889</u>	
9. AGE last birthday: <u>65</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Months		Days		Hours		Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Edward L. Fogle</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Virginia Kaemmer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Marvin Staley, Walkersville, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Diabetes, Mel.</u>							
DUE TO							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>1-16, 1955</u> , to <u>7-16, 1955</u> , that I last saw the deceased alive on <u>7-15, 1955</u> and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Legg</u>				ADDRESS <u>Verney Bridge</u>		DATE SIGNED <u>7-18-55</u>	
M.D. <u>Verney Bridge</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rocky Hill Lutheran Church</u>		LOCATION (City, town, or county) (State) <u>Md. Woodsboro</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/18/55</u>		REGISTRAR'S SIGNATURE <u>L. B. Powell</u>		24. FUNERAL DIRECTOR <u>H. C. Barton, Walkersville, Md.</u>		ADDRESS	

BUREAU V. S.

JUL 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

07742

Reg. Dist. No. 144

1. PLACE OF DEATH COUNTY Frederick		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Thurmont rural		CITY (If outside corporate limits, write RURAL and give nearest town) Thurmont Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS Thurmont (rural, give location) 1	
3. NAME OF DECEASED (Type or Print) JAMES WILLIAM KNOTT		4. DATE OF DEATH July 29 1955	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH March 24, 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE last birthday 2 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Guy Knott Jr.		14. MOTHER'S MAIDEN NAME Eliza Sweeney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		17. INFORMANT AND ADDRESS Guy Knott Jr., Thurmont, Md. R.D.1	
16. SOCIAL SECURITY NO.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause 9/6.0 Incendication, asphyxiation			10 Min
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last House caught on fire			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, or office bldg, etc.) None	(CITY OR TOWN) Thurmont (COUNTY) Frederick (STATE) Co. Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY 7/29/55/10:25 m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE R. W. Bace M.D. - Dept. Med. Ex., Frederick		DATE SIGNED 7/30/55	
23. BURIAL, CREMATION OR REINTERMENT (Specify) burial		DATE THEREOF Aug. 1, 1955	
NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		LOCATION (City, town, or county) Thurmont Md. (State)	
DATE REC'D BY LOCAL REG. Aug. 1 1955		REGISTRAR'S SIGNATURE Blanche S. Eyles	
FUNERAL DIRECTOR & Son Thurmont		ADDRESS	

BUREAU V. S.

AUG 9 1955

RECEIVED

06667

MARYLAND STATE DEPARTMENT OF HEALTH

6630

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 140

1. PLACE OF DEATH- COUNTY <u>Frederick Co</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u> TOWN <u>Woodstock</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>280 S. Seton St.</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg, Frederick Co</u> TOWN <u>Emmitsburg</u> STREET ADDRESS (If rural, give location) <u>280 S. Seton St.</u>	
3. NAME OF DECEASED (Type or Print) <u>James</u> (First) <u>Everett</u> (Middle) <u>Knox</u> (Last)		4. DATE OF DEATH <u>7</u> (Month) <u>30</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 13, 1932</u>
9. AGE last birthday <u>22</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Knox</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Baumgardner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-30-2930</u>	
17. INFORMANT AND ADDRESS <u>Charles W. Knox</u> <u>280 S. Seton St.</u> <u>Emmitsburg</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Electrocution

INTERVAL BETWEEN ONSET AND DEATH

Immediate

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	(CITY OR TOWN) <u>Woodstock</u> (COUNTY) <u>Frederick</u> (STATE) <u>MD.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/30/55</u> P.m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Flying into high tension line</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Aug. 2, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>	LOCATION (City, town, or county) <u>Keysville, Maryland</u> (State)
DATE REC'D BY LOCAL REG. <u>Aug 1 - 1955</u>	REGISTRAR'S SIGNATURE <u>W. F. Schuff</u>	24. FUNERAL DIRECTOR <u>S. L. Allison</u>	ADDRESS <u>Emmitsburg, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 8 1955

RECEIVED

6631

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> <u>Rural Middletown</u>		<u>life</u>		<u>X</u> <u>Rural Middletown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Bruce Sheffer Koogle</u>				<u>7 28 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>9-21-1906</u>	<u>48</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>farm owner</u>				<u>farm</u>		<u>Maryland</u>	
12. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>Calvin P. Koogle</u>				<u>U.S.</u>			
13. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				15. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>						<u>Mrs. Doris Koogle, Middletown, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE						<u>1 day</u>	
(A) <u>Acute Coronary Thrombosis</u>							
ANTECEDENT CAUSE (S)							
(B) <u>Coronary Artery disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/26</u> , 19 <u>54</u> , to <u>7/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 15</u> , 19 <u>55</u> , and that death occurred at <u>6:30 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Kenneth C. Nenson</u>				DATE SIGNED <u>7/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>7-31-1955</u>		<u>Lutheran Cemetery Middletown, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>31 July 1955</u>		<u>Elizabeth B. Heck</u>		<u>Gladhill Co., Middletown, Md.</u>			

MARGIN RESERVED FOR BINDING

RECEIVED

AUG 4 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6632 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06669

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Cullen		210 days		OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital				STREET ADDRESS (If rural give location) 125 Cheapside Ave., Baltimore, Md.			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) Mike		(Middle)		(Last) Kosz		July 14, 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	single	Dec. 29, 1884	70 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mercy Hospital Worker			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Austria		12. CITIZEN OF WHAT COUNTRY? ?
13. FATHER'S NAME: Tom Kosz				14. MOTHER'S MAIDEN NAME: Mary Legyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 203-07-6063		17. INFORMANT & ADDRESS: Mike Kosz, 125 Cheapside Ave., Balto., Md.	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral apoplexy				2 days.			
ANTECEDENT CAUSE (S) DUE TO (B) Generalized arteriosclerosis				Unknown.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 002X				(C) Pulmonary Tuberculosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				2 years.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 16, 19 54 , to July 14, 19 55 , that I last saw the deceased alive on July 14, 19 55 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
SIGNATURE [Signature]		M. D. Cullen, Md.		DATE SIGNED July 15, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-5-55		NAME OF CEMETERY OR CREMATORY Loudon Park		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR 7/15/55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Wm. Teikner, Balto., Md.		ADDRESS	

BUREAU V. 4

JUL 19 1955

RECEIVED

6633

MARYLAND STATE DEPARTMENT OF HEALTH

06670

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Mt. Union, Pa.</u> COUNTY <u>Pa.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Near Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mount Union</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Grove Lime Plant</u>		STREET ADDRESS (If rural, give location) <u>132 West Halley Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CLEMENT</u>	(Middle) <u>GEORGE</u>	(Last) <u>KROUSE</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	4. DATE OF DEATH <u>July 28, 1955</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner and Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	8. DATE OF BIRTH <u>Oct. 10, 1910</u>	9. AGE last birthday <u>44</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Wilson S. Krouse</u>	
14. MOTHER'S MAIDEN NAME <u>Caroline Geir</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>201-10-9804</u>		17. INFORMANT AND ADDRESS <u>Mrs. Gretchen Krouse, 132 W. Halley Street, Mount Union, Penna.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1 Coronary occlusion</u>	<u>Immediate</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	<u>" Heart disease Unknown</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>near Frederick, Md.</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>July 31, 1955</u>	<u>I.O.O.F. Cemetery</u>	<u>Mount Union, Penna.</u>	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>29 July 1955</u>	<u>Elizabeth S. Heck</u>	<u>M. R. Etchison & Son,</u>	<u>Frederick, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 1 1955

BUREAU V. S.

6634

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Frederick-Rural R.F.D.#2		Life		TOWN Frederick-Rural R. F. D. #2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Park Mills Rd. (Near Urbana)				STREET ADDRESS (If rural give location) Park Mills Rd. (Near Urbana)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
EFFIE ELLEN LENHART				July 4, 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow		8. DATE OF BIRTH: February 21, 1879	
9. AGE last birthday: 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: James E. White				14. MOTHER'S MAIDEN NAME: Mary E. Perrell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Claude O. Lenhart, Frederick R. F. D. #2, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						420.2	
IMMEDIATE CAUSE (A) <i>Angina pectoris</i>						3 1/2 hours	
ANTECEDENT CAUSE (S) (B) <i>Arterio Sclerosis</i>						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 4, 1955</i> , 1955, to <i>July 4, 1955</i> , that I last saw the deceased alive on <i>July 4, 1955</i> , and that death occurred at 6:15 PM, from the causes and on the date stated above.							
SIGNATURE <i>E. O. Lenhart</i>				ADDRESS DATE SIGNED Frederick, Maryland 7/5/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 7, 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
5 July 1955 -		<i>Elizabeth H. Heck</i>		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 6 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

6642

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

06672

1. PLACE OF DEATH - COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>XXXXXX</u> MD COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mountaineale</u>	
TOWN <u>Frederick</u>		TOWN <u>Mountaineale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Mem. Hospital</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) <u>SARAH</u> (Middle) <u>ANN</u> (Last) <u>MARSHALL</u>		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX <u>Female</u> COLOR OR RACE <u>White</u>		6. DATE OF BIRTH <u>Dec 31, 1875</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. AGE last birthday <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home wife</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. MD</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm. R. May</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Ambrose</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. MEDICAL CERTIFICATION		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Cranial occlusion</u>		3 hrs.	
Antecedent cause(s) (b) <u>Disease nr conditions, If any, giving rise to the above cause stating the underlying cause last</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>P.W. Bauer</u>		DATE SIGNED <u>7/14/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 18, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Lewistown Cem</u>		LOCATION (City, town, or county) (State) <u>Lewistown Fredk Co. Md</u>	
DATE REC'D BY LOCAL REG. <u>16 July 1955</u>		24. FUNERAL DIRECTOR <u>M. L. Creager & Son</u>	
FURNER'S SIGNATURE <u>Eligible S. Herb</u>		ADDRESS <u>Thurmont Md</u>	

BUREAU V. S.

JUL 19 1955

RECEIVED

6643

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	LENGTH OF STAY (in this place) <i>Lifetime</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>354 W. Patrick St.</i>		STREET ADDRESS (If rural give location) <i>354 W. Patrick St.</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Franklin</i>	(Middle) <i>David</i>	(Last) <i>Miller</i>	(Month) <i>7</i> (Day) <i>4</i> (Year) <i>1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>5-10-1880</i>
9. AGE last birthday: <i>75</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Cabinet maker</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Lumber yard</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>Pierce Miller</i>		14. MOTHER'S MAIDEN NAME: <i>Cora Cramer</i>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>214-10-2416</i>	
17. INFORMANT & ADDRESS: <i>Frederick-Md.</i>		<i>Mrs. Clayton Morgan - Willow Ave.</i>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
330X Immediate cause (a) <i>Subarachnoid Hemorrhage</i>		<i>3 hrs.</i>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Atherosclerosis</i>		<i>34 yrs +</i>	
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
	INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 4, 1955</i> , to <i>July 4, 1955</i> , that I last saw the deceased alive on <i>July 4, 1955</i> , and that death occurred at <i>5 a/m</i> , from the causes and on the date stated above.			
SIGNATURE <i>B. P. Thompson</i>		DATE SIGNED <i>July 5-1955</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>		<i>7-6-1955</i>	<i>Mt. Olivet Cemetery</i>
LOCATION (City, town, or county) (State)		<i>Frederick-Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<i>5 July 1955</i>		<i>Elizabeth G. Heck</i>	<i>C. E. Cline & Son - Frederick-Md.</i>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Waltz
Winfield.

6644

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

06674

1. PLACE OF DEATH - COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD.</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dorchester</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>F. ed. Mem. Hosp.</u>				STREET ADDRESS <u>Woodbine, P.D.</u>			
3. NAME OF DECEASED (Type or Print) <u>Kenneth</u>		(First) <u>B.</u> (Middle) <u>1701111111</u> (Last) <u>X</u>		4. DATE OF DEATH <u>July 4</u>		(Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 28, 1925</u>	9. AGE last birthday <u>29</u> yrs.	If under 1 year Months Days		If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>G. Robey Mullinix</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Martin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>424-</u>		17. INFORMANT AND ADDRESS <u>Mrs. Robey Mullinix, Woodbine</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
823 Immediate cause (a) <u>Crushing injury to left chest</u>						1 hr.	
Antecedent cause(s) (b) <u>Stroke, hemiplegia</u>							
(c) <u>stating the underlying cause last</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION <u>Do</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Route 94 near Woodbine Cemetery</u>		(CITY OR TOWN) <u>Woodbine</u>		(COUNTY) <u>Dorchester</u> (STATE) <u>MD.</u>	
CAUSE OF DEATH.		INJURY		HOW DID INJURY OCCUR?			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<u>1</u> <u>Ran off road and hit a tree.</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>R. W. Barr M.D.</u>				ADDRESS <u>Frederick, Md.</u>		DATE SIGNED <u>July 4 55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 7 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Int. Carmel Cemetery</u>		LOCATION (City, town, or county) <u>Montgomery Co. Md.</u> (State) <u>MD.</u>	
DATE REC'D BY LOCAL <u>7 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		24. FUNERAL DIRECTOR <u>C. M. Waltz Jr.</u>		ADDRESS <u>Winfield, Md.</u>	

BUREAU V. 2

JUL 11 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6685

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06675

CERTIFICATE OF DEATH

Reg. Dist. No. 131.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Braddock Heights</u>		Week		TOWN <u>Frederick-Rural # R. F. D. #6.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vindabona Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>Near Frederick</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>LAURA</u> <u>REBECCA CATHERINE</u> <u>OLAND</u>				OF DEATH: <u>July 20,</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>March 28, 1890</u>	<u>65</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housework</u>				<u>Home</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>USA</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Claude Dutrow</u>				<u>Ida Beck</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Sharretts E. Oland, Frederick, R.F.D. #6, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Oesophagus</u>							<u>6 months</u>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cachexia</u>							<u>1 week</u>
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 16, 1955</u> , to <u>July 20, 1955</u> , that I last saw the deceased alive on <u>July 19, 1955</u> , and that death occurred at <u>3:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. Lamona Fabray</u>				ADDRESS <u>Frederick, Maryland</u>		DATE SIGNED <u>7/21/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 22, 1955</u>		<u>Mount Olivet Cemetery</u>		<u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>22 July 1955</u>		<u>Elizabeth G. Herb</u>		<u>M. R. Etchison & Son, Frederick, Maryland</u>			

BUREAU V. B.

JUL 25 1955

RECEIVED

6645

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fred. Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>Walkersville</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>John</u>		(Middle) <u>Oliver</u>		(Last) <u>Poole, Jr.</u>	
4. DATE (Month) (Day) (Year)		OF DEATH: <u>July</u> <u>30</u> <u>1955</u>					
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. <u>MARRIED</u> (Specify)	8. DATE OF BIRTH: <u>Dec. 8, 1909</u>	9. AGE last birthday <u>45</u> yrs.	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	12. IF UNDER 48 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Glade Valley Bakery</u>		11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME: <u>John Oliver Poole</u>				14. MOTHER'S MAIDEN NAME: <u>Ells. Elizabeth Rustam</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-10-2533</u>		17. INFORMANT & ADDRESS: <u>Mrs. John O. Poole, Walkersville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute myeloid leukemia</u>						<u>3 months</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 April</u> , 19 <u>55</u> , to <u>30 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>30 July</u> , 19 <u>55</u> and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James E. Stoner, Jr.</u> MD				DATE SIGNED <u>30 July 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Chapel</u>		LOCATION (City, town, or county) (State) <u>M. Libertytown Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-Aug-1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		24. FUNERAL DIRECTOR <u>G.C. Barton</u>		ADDRESS <u>Walkersville, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 3 1955

BUREAU V. S.

6646

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) 11 Town Frederick	LENGTH OF STAY (in this place) Since 6/28/55	CITY (If outside corporate limits, write RURAL and give nearest town) Town Mount Airy-Rural	06X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital		STREET ADDRESS (If rural give location) Near Mount Airy	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) BRICE	(Middle) L.	(Last) RUNKLES	(Month) July 2, (Day) 1955
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 7 Jan 1882
9. AGE last birthday: 73 yrs.		10. MONTHS: Days: Hours: Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer		10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Brice Runkles		14. MOTHER'S MAIDEN NAME: Mary Ellen Wilhelm	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None	
17. INFORMANT & ADDRESS: Mrs. Zelma N. Runkles, RD., Mount Airy, Md.			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
610X Immediate cause (a) <u>Wrenia</u>		1 week
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Nephrosclerosis</u>		6 months
(c) <u>Prostatism - benign hypertrophy</u>		1 year
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Angustic Heart Failure</u>		1 month
19a. DATE OF OPERATION: 0	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 29 June, 1955, to 2 July, 1955, that I last saw the deceased alive on 2 July, 1955, and that death occurred at 10:50 AM, from the causes and on the date stated above.		
SIGNATURE <u>Thomas S. Stone</u> (Degree or title) M.D.		DATE SIGNED 7-3-55
23. BURIAL, CREMATION, (Specify) Burial	DATE THEREOF 5 July 1955	NAME OF CEMETERY OR CREMATORY Prospect Cemetery
LOCATION (City, town, or county) (State) Frederick County Maryland	DATE REC'D BY LOCAL REGISTRAR 3 July 1955	REGISTRAR'S SIGNATURE Elizabeth B. Heck
24. FUNERAL DIRECTOR C. M. Waltz, Winfield, Maryland	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 2 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06678

CERTIFICATE OF DEATH

Reg. Dist. No. 131

6647
141 Filing 8/1/55

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Md		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick		LENGTH OF STAY (in this place) 4 da.		CITY (If outside corporate limits, write RURAL and give nearest town) OR Thurmont Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Mem. Hospital				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (First) (Middle) (Last) Oscar Richard Saylor				4. DATE (Month) (Day) (Year) OF DEATH: 7 23 1955			
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Dec. 5th. 1894	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): Clerk		10B. KIND OF BUSINESS OR INDUSTRY: Cambridge Rubber Co		11. BIRTHPLACE (State or foreign country): Frederick Co. Md		12. CITIZEN OF WHAT COUNTRY? U.S. A	
13. FATHER'S NAME: Marshall Saylor				14. MOTHER'S MAIDEN NAME: Ellen Linn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 204-16-7214		17. INFORMANT & ADDRESS: Edna Saylor Rocky Ridge Md	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 443X							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Cerebral hemorrhage						4 days	
(B) Hypertensive Cardiovascular disease						2 yrs.	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Bronchitis						10 yrs.	
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/20 , 19 55 , to 7/23 , 19 55 , that I last saw the deceased alive on 7/23 , 19 55 , and that death occurred at 12 PM , from the causes and on the date stated above.							
SIGNATURE Henry V. Chase		DATE THEREOF 7/23/55		NAME OF CEMETERY OR CREMATORY M. D. & E. Church St Frederick Md		LOCATION (City, town, or county) (State) 7/23/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 26, 1955		NAME OF CEMETERY OR CREMATORY Rocky Ridge Cem.		LOCATION (City, town, or county) (State) Rocky Ridge Fredk Co. Md	
DATE REC'D BY LOCAL REGISTRAR 26 July 1955		REGISTRAR'S SIGNATURE Elizabeth B. Heik.		24. FUNERAL DIRECTOR M.L. Creager & Son		ADDRESS Thurmont MD	

RECEIVED

JUL 27 1955

BUREAU V. S.

6686

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
(If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		(If outside corporate limits, write RURAL and give nearest town)			
X TOWN Adamstown		Life		TOWN Adamstown		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				/			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) JOHN		(Middle) FENTON		(Last) SCARFF Jr.		July 11, 1955	
(Type or Print)							
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: August 8, 1910	
				9. AGE last birthday: 41 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman				10B. KIND OF BUSINESS OR INDUSTRY: Painter		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: John F. Scarff Sr.				14. MOTHER'S MAIDEN NAME: Grace Irene Rager			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 578-09-3521		17. INFORMANT & ADDRESS: Mrs. Helen P. Scarff, Adamstown, Maryland	
(If Yes, give war or dates of service) No							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) DUE TO Coronary artery disease						2 years	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 1, 1953, to July 10, 1955, that I last saw the deceased alive on 6-23, 1955, and that death occurred at 10:45 M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
Elizabeth B. Hack				Frederick, Maryland		7/12/1955	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 14, 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
13 July 1955		Elizabeth B. Hack		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 15 1995

BUREAU V. S.

6648

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 11 TOWN Frederick		LENGTH OF STAY (in this place) Lifetime		CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 203 West Second Street			
3. NAME OF DECEASED:		(First) FLORENCE		(Middle) GERTRUDE		(Last) SCHROEDER	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		4. DATE OF DEATH: July 27 1955	
8. DATE OF BIRTH: June 7, 1900		9. AGE last birthday: 55 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Bank teller				10b. KIND OF BUSINESS OR INDUSTRY: Banking		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME: Frank J. Schroeder			
14. MOTHER'S MAIDEN NAME: Lillie May Scholl				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No			
16. SOCIAL SECURITY No.: 216-14-6042				17. INFORMANT & ADDRESS: Mrs. Robert L. Smith - Frederick, Md. (sister)			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
170x Immediate cause (a) Carcinoma of Rt Breast						2 years	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Metastases to Lungs and Bones							
(c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. Hypertrophic Arthritis							
19a. DATE OF OPERATION: July 3, 1953				19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Breast with Axillary Metastases			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify) No		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 25, 1953, to July 27, 1955, that I last saw the deceased alive on July 27, 1955, and that death occurred at 1:05 A.M. from the causes and on the date stated above.							
SIGNATURE: U.A. Searre, M.D.		ADDRESS: Frederick, Md.		DATE SIGNED: 7/28/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF: July 29, 1955		NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR: 28 July 1955		REGISTRAR'S SIGNATURE: Elizabeth B. Heck		24. FUNERAL DIRECTOR: C. E. Cline & Son - 8 East Patrick Street		ADDRESS: Frederick, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

THE STATE OF NEW YORK

County of ...
City of ...
State of New York

Age ...
Sex ...
Race ...

Married ...
Occupation ...
Cause of Death ...

Decided by the Board of Health ...
Signed and sealed this ... day of ...
1955

Signature of ...
Official Capacity ...

Signature of ...
Official Capacity ...

BUREAU V. S.

JUL 29 1955

RECEIVED

6649

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montg.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frederick</u>	LENGTH OF STAY (in this place) <u>13 days</u>	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Damascus</u>	<u>15X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Mem. Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <u>Madelene</u> (Middle) <u>V.</u> (Last) <u>Scott</u>		4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DECEASED , (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 13, 1890</u>
9. AGE last birthday: <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Clarksburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Louis Bell King</u>		14. MOTHER'S MAIDEN NAME: <u>Emma J. Hurley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Albert R. Scott, Damascus, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
<u>332X</u> Immediate cause (a) <u>Cerebral Thrombosis</u> DUE TO Antecedent causes (s) (b) <u></u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u></u>		<u>13 days</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 10</u> , 19 <u>55</u> , to <u>July 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 23</u> , 19 <u>55</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. SIGNATURE (Degree or title) <u>Bernard O. Thomas, M.D.</u> ADDRESS <u>Frederick, Md.</u> DATE SIGNED <u>July 23, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 25, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Damascus</u> LOCATION (City, town, or county) (State) <u>Damascus, Montg. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>24 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u> 24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 26 1955

RECEIVED

6650

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Frederick</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Frederick</u>		
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Frederick</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>217 East Patrick Street</u>			STREET ADDRESS (If rural give location) <u>217 East Patrick Street</u>		
3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year) OF DEATH:		
(First) (Middle) (Last) <u>WILLIAM</u> <u>HAROLD</u> <u>SCOTT, SR.</u>			<u>July 3,</u> <u>1955</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	10. IF UNDER 1 YEAR Months Days
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>17 Aug 1900</u>	<u>54</u>	<u>0</u> <u>0</u> <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		
<u>Foreman</u>			<u>Railroad Company</u>		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
<u>Maryland</u>			<u>USA</u>		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Ulysses G. Scott, Sr.</u>			<u>Alice Miles</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
<u>No</u>			<u>705-05-5553</u>		
17. INFORMANT & ADDRESS:			217 E. Patrick St., Mrs. Madeline C. Scott, Frederick, Md.		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
420.0 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>					<u>Sudden</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arter. Sclerotic Heart Disease</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6-10</u> , 19 <u>55</u> to <u>July 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>55</u> , and that death occurred at <u>7:45A</u> M, from the causes and on the date stated above.					
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M. D. Frederick, Maryland</u> DATE SIGNED <u>5 July 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>6 July 1955</u>		<u>Mount Olivet Cemetery</u>	
LOCATION (City, town, or county) (State)		<u>Frederick, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>5 July 1955</u>		<u>[Signature]</u>		<u>M. R. Etchison & Son, Frederick, Maryland</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

JUL 6 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06683

6687

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH: COUNTY Frederick CITY (If outside corporate limits, write RURAL and give nearest town) Thurmont Rural TOWN Thurmont		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Frederick CITY (If outside corporate limits, write RURAL and give nearest town) Rural Thurmont OR TOWN Thurmont	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural give location) Near Thurmont	
3. NAME OF DECEASED: (Type or Print) Assard (First) Seipier (Middle)		4. DATE OF DEATH: July 29 19 55	
5. SEX: male	6. COLOR OR white	7. SINGLE, MARRIED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: April 6, 1877
9. AGE last birthday 78 yrs.		10. IF UNDER 1 YEAR: 3 Months 5 Days IF UNDER 24 HRS.: 19 Hours 5 Min.	
10A. USUAL OCCUPATION (Give kind of work done during working life, even if retired): Laborer		10B. KIND OF BUSINESS: Saw Mill	
11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: George Seipier		14. MOTHER'S MAIDEN NAME: Catherine Feller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-18-07001	
17. INFORMANT & ADDRESS: Mrs. Charles Carty Thurmont Rd I			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 422.1			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(A) Pulmonary edema			3 hrs.
(B) Chronic myocarditis			?
(C) Arteriosclerosis			?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 7, 1947 , to July 29, 1955 , that I last saw the deceased alive on July 29, 1955 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.			
SIGNATURE M. J. Seipier		DATE SIGNED July 30, 1955	
23. BURIAL, CREMATION, REINTERMENT (SPECIFY) Burial		DATE THEREOF Aug. 1 55	
NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		LOCATION (City, town, or county) (State) Thurmont Md.	
DATE REC'D BY LOCAL REGISTRAR Aug. 1, 1955		24. FUNERAL DIRECTOR M.L. Creager & Son	
REGISTRAR'S SIGNATURE Blauche S. Egler		ADDRESS Thurmont	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, cause of death, and place of death. The form is divided into several columns and rows for detailed data entry.

BUREAU V. 2

AUG 4 1955

RECEIVED

6638

CERTIFICATE OF DEATH

Reg. Dist. No. 131.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Middletown</i>		<i>10 yrs</i>		OR TOWN <i>Middletown</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
OF DEATH: (Type or Print) <i>Effie V. Shafer</i>				OF DEATH: <i>7 8 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>white</i>	<i>married</i>	<i>4-5-1891</i>	<i>64</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>housewife</i>		<i>own home</i>		<i>Maryland</i>		<i>U. S.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>George P. Stiles</i>				<i>Frances Sabington</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<i>no</i>				<i>none</i>			
17. INFORMANT & ADDRESS:							
<i>Joseph Shafer, Middletown, Md.</i>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis, acute.</i>						<i>1 hr</i>	
ANTECEDENT CAUSE (S) (B) <i>arteriosclerosis, advanced,</i>						<i>?</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>generalized.</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<i>0</i>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 8, 1955</i> , to <i>July 8, 1955</i> , that I last saw the deceased alive on <i>July 8, 1955</i> , and that death occurred at <i>10:30 P.</i> M., from the causes and on the date stated above.							
SIGNATURE <i>Bluneth C. Wilson</i>				ADDRESS <i>Middletown, Md.</i>			
DATE SIGNED <i>7/8/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>7-11-1955</i>		<i>Lutheran Cemetery</i>		<i>Middletown, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<i>11 July 1955</i>		<i>Elizabeth G. Heck</i>		<i>Shadhill Co.</i>		<i>Middletown, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 13 1955

RECEIVED

6689

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Burkittsville</u>				OR TOWN <u>Burkittsville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
OF DECEASED: (Type or) <u>Harry P. Shafer</u>				OF DEATH: <u>7 6 1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>12-28-1870</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>machinist, fct.</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>farm</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME: <u>Peter Shafer</u>			14. MOTHER'S MAIDEN NAME: <u>Susan Kora</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Elizabeth Shafer, Burkittsville</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>442X Cardio-Renal Vascular disease</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>July 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 4</u> , 19 <u>55</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J E Hays</u>		M. D. <u>Middletown</u>		DATE SIGNED <u>7-7-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-8-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		24. FUNERAL DIRECTOR <u>Bladhill Co.</u>		ADDRESS <u>Middletown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 11 1955

BUREAU V. S.

6690

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Frederick-Rural RD#5		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Frederick-Rural RD#5			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rocky Springs				STREET ADDRESS (If rural give location) Rocky Springs			
3. NAME OF DECEASED: (First) (Middle) (Last) LESTER EZRA SHAFER				4. DATE (Month) (Day) (Year) OF DEATH: July 4, 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 25 Dec 1889	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10B. KIND OF BUSINESS OR INDUSTRY: Farm Owner		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George C. Shafer				14. MOTHER'S MAIDEN NAME: Laura Toms			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 4 No			16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Mrs. Abbie F. Shafer, RD#5, Frederick, Md.		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 420.0						3 days	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						year	
(A) Cerebral hemorrhage							
(B) Hypertensive arteriosclerotic heart disease							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/29, 1955 , to 7/4, 1955 , that I last saw the deceased alive on 7/2, 1955 , and that death occurred at 4 A M, from the causes and on the date stated above.							
SIGNATURE James B. Thomas				ADDRESS M. D. Frederick, Maryland		DATE SIGNED 5 July 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7 July 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 6 July 1955		REGISTRAR'S SIGNATURE Elizabeth B. Hedek		24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1955

BUREAU V. S.

6691

CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
OR (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		OR (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Middletown</i>				OR TOWN <i>Middletown</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Charles E. Stine</i>				OF DEATH: 7 4 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>male</i>	<i>white</i>	<i>widowed</i>	<i>1-30-1877</i>	<i>78</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
				<i>Maryland</i>		<i>U.S.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Philip L. Stine</i>				<i>Laura Rautzahn</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>no</i>						<i>C. Glenn Stine, Middletown, Md.</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
199.1 IMMEDIATE CAUSE (A) <i>General Carcinomatosis (abdominal)</i>							? 12 mo
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
<i>1 March '55</i>		<i>Carcinoma</i>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb</i> , 1955, to <i>July 4</i> , 1955; that I last saw the deceased alive on <i>July 3</i> , 1955, and that death occurred at <i>7 P.</i> from the causes and on the date stated above.							
SIGNATURE <i>J. E. Harp</i>		ADDRESS <i>Middletown</i>		DATE SIGNED <i>7-5-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<i>Burial</i>		<i>7-7-1955</i>		<i>Elizabeth B. Harp</i>		<i>Gladhill Co., Middletown, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 11 1955

BUREAU V. S.

6692

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Walkersville		Years		OR TOWN Walkersville		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pennsylvania Avenue				STREET ADDRESS (If rural give location) Pennsylvania Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
(Type or Print) CLAUDE WILLIAM STULL				July 12, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	12. CITIZEN OF WHAT COUNTRY?
Male	White	Married	17 Dec 1900	54 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Salesman		Watkins Products		Maryland			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Thomas M. Stull				Minnie Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
3 No (If Yes, give war or dates of service)		214-10-2984		Mrs. Margaret W. Stull, Walkersville, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary thrombosis & myocardial infarction</u>						10 min	
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerotic CVD</u>						10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes mellitus</u>						15 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic glomerular nephritis</u>						4 yrs	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1 April, 1949, to 11 July, 1955, that I last saw the deceased alive on 11 July, 1955, and that death occurred at 4:30 A M, from the causes and on the date stated above.							
SIGNATURE <u>Samuel S. Stull Jr.</u>				M. D. <u>Walkersville, Md</u>		DATE SIGNED <u>14 July 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		14 July 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
14 July 1955		<u>Elizabeth B. Heck.</u>		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 15 1966

BUREAU W. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06689

6651

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 11 Frederick		LENGTH OF STAY (in this place) Since 2/21/48		OR (If outside corporate limits, write RURAL and give nearest town) TOWN Adamstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home for the Aged				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (First) (Middle) (Last) CORA BELLE THOMAS				4. DATE (Month) (Day) (Year) OF DEATH: July 3, 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 30 Sept 1869	9. AGE last birthday: 85 yrs.	10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work		10B. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Daniel Peter Thomas				14. MOTHER'S MAIDEN NAME: Elizabeth Rebecca Remsburg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 4 No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Home for the Aged Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.0 Arterio-sclerotic heart di						5+ yrs.	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1950, to 3 July, 1955, that I last saw the deceased alive on 1 July, 1955, and that death occurred at 10 P. M. from the causes and on the date stated above. SIGNATURE: Charles H. Conley, M.D. ADDRESS: Frederick, Maryland DATE SIGNED: 5 July 1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6 July 1955		NAME OF CEMETERY OR CREMATORY Reformed Cemetery		LOCATION (City, town, or county) (State) Church Hill-Fred'k Co. Md.	
DATE REC'D BY LOCAL REGISTRAR 6 July 1955		REGISTRAR'S SIGNATURE Elizabeth B. Hark		24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland			

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JUL 7 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06690

6693

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Fredenich</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <i>Bradlock Regats</i>		<i>5 mo</i>		OR TOWN <i>Baltimore</i>		<i>3701-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Windelona Ann Home</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>Fannetta Turner</i>				<i>July 24 1957</i>			
5. SEX: <i>female</i>		6. COLOR OR RACE: <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED , (Specify): <i>widowed</i>		8. DATE OF BIRTH: <i>Mar 1 1877</i>	
				9. AGE last birthday: <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
13. FATHER'S NAME: <i>James Moley</i>				14. MOTHER'S MAIDEN NAME: <i>Emily Todd</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) <i>9</i>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mrs. Dan Weinberg</i>	
				18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause (a) <i>443X Acute left side heart failure & pulmonary edema</i>				<i>1 hr</i>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Hypertensive cardio vascular disease</i>				<i>1 year plus</i>			
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Cerebral thrombosis with right hemiplegia</i>				<i>5 1/2 mos</i>			
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March 1955</i> , to <i>July 24, 1957</i> , that I last saw the deceased alive on <i>July 24, 1957</i> , and that death occurred at <i>11:00 AM</i> , from the causes and on the date stated above.							
SIGNATURE (Degree or title) <i>L. R. Schoolman M.D.</i>				ADDRESS <i>228 N. Market St. Fredenich</i>		DATE SIGNED <i>7/24/57</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>7/27/57</i>		<i>Towson Park</i>		<i>Baltimore Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>25 July 1957</i>		<i>Elizabeth S. Heik</i>		<i>H. C. Cartledge Fredenich</i>		<i>Md</i>	

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BUREAU V. 3

JUL 26 1965

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6691

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X Rural - Braddock</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>X Rural - Utica</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) (Middle) (Last) <i>ISABELLE WACHTER</i>		<i>July 27 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>F</i>	<i>W</i>	<i>Married</i>	<i>—</i>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
<i>75</i> yrs.		<i>USA</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>USA</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>John Leuhart</i>		<i>Rebecca Baker</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
<i>no</i>		<i>—</i>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<i>Mrs. Albert J. Main, Fred - R.F. 105.</i>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
IMMEDIATE CAUSE <i>450.0</i>		DUE TO <i>Pneumonia</i>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO <i>Generalized arteriosclerosis</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>Years</i>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>0</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May</i> , 1955, to <i>July 27</i> , 1955, that I last saw the deceased alive on <i>July 27</i> , 1955, and that death occurred at <i>11:50 P</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Robert S. Turner, Jr.</i>		DATE SIGNED <i>7-29-55</i>	
ADDRESS <i>M. D. 7 E. Church St. Frederick</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<i>Burial</i>		<i>W.C. Barton, Walkersville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>29 July 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth B. Heck</i>	

MARGIN RESERVED FOR BINDING

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U.S. DEPARTMENT OF JUSTICE

BUREAU V. E.

AUG 1 1955

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13. (12/12/31) 11:40 AM
Refer to Bureau of
11:40 AM

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 18, Film G184, 8-9-55 ams,

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G184 8-4-55 et

06692

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) OR Frederick		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR Point of Rocks			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) EULICE (Middle) DEXTER (Last) WALLACE				4. DATE OF DEATH: (Month) July (Day) 12, (Year) 1955			
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 1892 December 5, 1892	
9. AGE last birthday: 62 yrs.		10. USUAL OCCUPATION, Give kind of work done during most of working life, even if retired: Laborer		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas Wallace				14. MOTHER'S MAIDEN NAME: Lucy Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: Mrs. Sarah F. Wallace, Point of Rocks, Md.			
18. MEDICAL CERTIFICATION							Interval Between Onset and Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
343X Immediate cause (a) Encephalomyelitis, etiology undetermined, question viral							12 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS							Unk.
Conditions contributing to the death but not related to the disease or condition causing death. Bronchiectasis							
19a. DATE OF OPERATION: 2				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1, 1955, to July 12, 1955, that I last saw the deceased alive on July 12, 1955, and that death occurred at 8:30 P.M., from the causes and on the date stated above.							
SIGNATURE Rex R. Martin M.D.				ADDRESS 35 E Church Frederick Md		DATE SIGNED 7-12-55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF July 15, 1955		NAME OF CEMETERY OR CREMATORY Fairview Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 14 July 1955		REGISTRAR'S SIGNATURE Elizabeth B. Heck		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

BUREAU V. 1

JUL 15 1955

RECEIVED

6695

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Cullen		3535 days.		TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital				STREET ADDRESS (If rural give location) 2932 Edmonston Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
William C. Walter				July 4 1955			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		White		Single		June 9, 1882	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
73 yrs.		Months Days		Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ship Rigger				10B. KIND OF BUSINESS OR INDUSTRY: Ship Rigger		11. BIRTHPLACE (State or foreign country): Baltimore, Md.	
13. FATHER'S NAME: Charles J. Walter				14. MOTHER'S MAIDEN NAME: Amanda Poulton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes World War I				16. SOCIAL SECURITY NO. 213-10-9569		17. INFORMANT & ADDRESS: Patient	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis						11 years.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 29, 1945 , to July 4, 1955 , that I last saw the deceased alive on July 4, 1955 , and that death occurred at 1:05 M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				a.m. ADDRESS Cullen, Md.		DATE SIGNED July 5, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-6-55		Loudon Park		Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR 7/5/55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR Wm. Tickner & Sons		ADDRESS	

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BUREAU V. 3.

JUL 6 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06694
6653 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>11 TOWN Frederick</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>11 TOWN Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 Frederick Memorial</u>				STREET ADDRESS (If rural give location) <u>90 Lincoln Apartments</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Betsy</u> <u>WARS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 2 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 1, 1955</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>ERLEST MCKINLEY TURNER</u>				14. MOTHER'S MAIDEN NAME: <u>FRANCES ELIZABETH INGRAM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>90 Lincoln Apts., Mrs. Frances E. Wars, Frederick, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>754.4 Congenital Heart Disease</u>						<u>15 hours</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>July 2, 1955</u> ; that I last saw the deceased alive on <u>July 2, 1955</u> , and that death occurred at <u>10 AM</u> , from the causes, and on the date stated above.							
SIGNATURE <u>Bernard Thomas Jr.</u>		ADDRESS <u>M. D. Frederick, Md.</u>		DATE SIGNED <u>July 2, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2 July 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2 July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hick</u>		24. FUNERAL DIRECTOR ADDRESS <u>Charles E. Hicks III Fred. Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18 Film G185 8-12-55 ~~ams~~

06695

6654

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		LENGTH OF STAY (in this place) 13 days		CITY (If outside corporate limits, write RURAL and give nearest town) Rural, Emmitsburg, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick City Hospital				STREET ADDRESS (If rural give location) Emmitsburg, R.D.# 3			
3. NAME OF DECEASED: (Type or Print) William Guy Wetzel				4. DATE OF DEATH: July 23 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: May 13, 1905	
9. AGE last birthday: 50 yrs.		10. MONTHS: 23		11. DAYS: 19		12. HOURS: 55	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Grit Mill				10b. KIND OF BUSINESS OR INDUSTRY: Driller		11. BIRTHPLACE (State or foreign country): Emmitsburg, Frederick Co	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME: Edward Wetzel				14. MOTHER'S MAIDEN NAME: Lucy Tressler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY No.: 220-10-5825		17. INFORMANT & ADDRESS: Roseba A. Wetzel, Emmitsburg, R.D.3		Md.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
104-1 Immediate cause (a) Broucho pneumonia						1 Day	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Histological lesions typical of Broucho pneumonia							
(c) Rooky Mountain Spotted Fever							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumoconiosis						Unknown	
19a. DATE OF OPERATION: 2						19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 9, 1955 , to July 23, 1955 , that I last saw the deceased alive on July 23, 1955 , and that death occurred at 1:30 pm , from the causes and on the date stated above.							
SIGNATURE J. W. Schorlemmer		ADDRESS W.D.		DATE SIGNED 2 25 14 1955			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF July 26, 1955		NAME OF CEMETERY OR CREMATORY Friends Creek		LOCATION (City, town, or county) (State) Emmitsburg, R.D.2 Md.	
DATE REC'D BY LOCAL REGISTRAR 26 July 1955		REGISTRAR'S SIGNATURE Elizabeth S. Hech		24. FUNERAL DIRECTOR S. L. Allison		ADDRESS Emmitsburg, Md.	

BUREAU V. S.

JUL 29 1955

RECEIVED

6655

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>11 TOWN Frederick</u>		LENGTH OF STAY (in this place) <u>27 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>106 Pennsylvania Avenue</u>				STREET ADDRESS (If rural give location) <u>106 Pennsylvania Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ROSALIE</u> <u>DEA</u> <u>ZEPP</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>July</u> <u>30</u> <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>September 28, 1879</u>	
9. AGE last birthday: <u>75</u> yrs.		10. MONTHS: <u>7</u>		11. DAYS: <u>30</u>		12. HOURS: <u>19</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>William O. Fish</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ann McMahon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>3 No</u>				16. SOCIAL SECURITY No.: <u>214-10-2456</u>		17. INFORMANT & ADDRESS: <u>Mr. William T. Zepp - Frederick, Maryland</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>443x</u> Immediate cause		<u>2 days</u>	
(a) <u>Subarachnoid hemorrhage</u> DUE TO			
(b) <u>Hypertensive cardiovascular disease</u> DUE TO		<u>10 yrs +</u>	
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from <u>Dec</u> , 19 <u>53</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>55</u> , and that death occurred at <u>12:45 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Leroy V. Chan</u>		DATE SIGNED <u>8/1/55</u>	
23. BURIAL, CREMATION, (Specify) <u>Burial</u>		DATE THEREOF <u>August 2, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1 August 1955</u>		24. FUNERAL DIRECTOR <u>C. E. Cline & Son - 8 East Patrick Street</u> <u>Frederick, Maryland</u>	

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

AUG 3 1905

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